Durable Medical Equipment (DME), Home Health and Home Infusion Services (UNIVITA TRANSITION)

Fall 2014

ambetter. FROM magnolia health

Mississippi Children's Health Insurance Program

12/15/2014

magnolia health™

Welcome to Magnolia Health!

We thank you for being part of or considering Magnolia's network of participating providers, hospitals, and other healthcare professionals. Our number one priority is the promotion of healthy lifestyles through preventive healthcare. Magnolia works to accomplish this goal by partnering with the providers who oversee the healthcare of Magnolia members.

Agenda

- Health plan Overview
- Centene Overview
- MississippiCAN & CHIP Overview
- Ambetter from Magnolia Health
- Member Eligibility
- Credentialing
- Benefits and Limitations
- Cultural Awareness and Sensitivity
- Abuse and Neglect
- Prior Authorizations
- Medical Management
- Claims Submission
- Appeals and Grievances
- Web Portal www.magnoliahealthplan.com
- Contacts
- Provider Relations
- Questions

Univita Transition

Effective **12/1/14**, Magnolia Health and Ambetter will resume responsibility for all **NEW** home Durable Medical Equipment, Home Health, Home Infusion, and custom equipment authorization requests previously handled by Univita, for all Magnolia Health and Ambetter members.

Univita Health will continue to manage Durable Medical Equipment, Home Health & Home Infusion Services and reimburse all claims for said services through **November 30, 2014**.

Members and Providers may contact Customer Service at 1-866-912-6285 (MHP/CHIP) or 1-877-687-1187 (Ambetter) with any questions you may have regarding this transition.

Magnolia Health Overview

- Medicaid Coordinated Care Organization (CCO)
- Contracted with Mississippi Division of Medicaid (DOM)
- Serving Mississippi Members in the MississippiCAN, Mississippi CHIP (eff. 01/01/15), and Ambetter (Health Insurance Exchange) Programs
- Goals:
  - Ensure access to primary and preventive services
  - Ensure care is delivered in the best setting
  - Encourage quality, continuity, and appropriateness of medical care

Centene Overview

Our Mission: Centene Will Provide Better Health At Lower Costs

- Founded as a single health plan in 1984, and headquartered in St. Louis, MO, Centene Corporation (Centene) has established itself as a national leader in the healthcare services field

- Today, through a comprehensive portfolio of innovative solutions, Centene remains deeply committed to delivering results for our stakeholders: state governments, members, providers, uninsured individuals and families, and other healthcare and commercial organizations

Centene Overview

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Core Business:

- Centene's core philosophy is that quality healthcare is best delivered locally. The local approach enables Centene to provide accessible, high quality and culturally sensitive healthcare services to our members

- Centene offers a full range of healthcare solutions for the rising number of uninsured Americans. Centene contracts with health plans and other commercial healthcare organizations to provide specialty services such as behavioral health, life and health management, managed vision, and pharmacy benefits

Centene Overview

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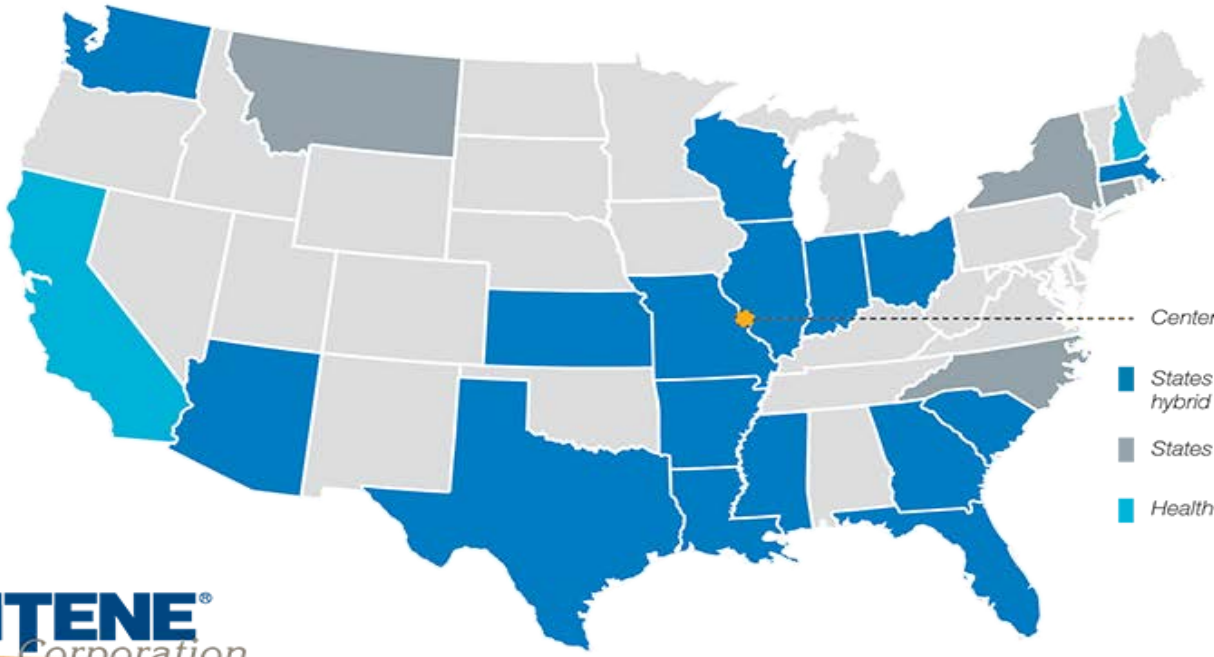
Arizona	Arkansas	California	Florida	Georgia	Illinois	Indiana	Kansas	Louisiana
Bridgeway	NovaSys Health	California Health & Wellness	Sunshine Health	Peach State Health Plan	IlliniCare Health Plan	mhs	Sunflower State Health Plan	Louisiana Healthcare Connections

Massachusetts	Mississippi	Missouri	New Hampshire	Ohio	South Carolina	Texas	Washington	Wisconsin
CeltiCare Health Plan of Massachusetts	Magnolia Health Plan	Home State Health Plan	Granite State Health Plan	Buckeye Community Health Plan	Absolute Total Care Total	Superior HealthPlan	coordinated care	MHS Managed Health Services



Partners with 18 States in 2013

CENTENE® Corporation

MississippiCAN Overview

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Key program dates:

- Request for Proposal released by DOM on January 27, 2009
- Proposals were submitted from Coordinated Care Organizations on March 16, 2009
- The DOM reviewed proposals and awarded a contract to Magnolia Health on November 24, 2009
- Enrollment effective date is proposed for January 1, 2011
- New contract awarded to Magnolia Health effective 07/01/2014

Target population includes current FFS Medicaid Consumers who also:

- are SSI eligible; or
- Disabled Children; or
- are identified as Working Disabled; or
- are Department of Human Services Foster Care, or
- are Breast/Cervical Cancer Program Members.
- Pregnant Members and Infants (0-1 & 8-65)
- Family/Children TANF (0-1 & 19-65)
- Children (0-1)

Excluded from Enrollment

- Persons in an institution such as a nursing facility, ICF/MR (Intermediate Care Facility of the Mentally Retarded) or PRTF (Psychiatric Residential Treatment Facility)
- Dual eligible's
- Waiver members (Home & Community Based Services)

The program is statewide covering all 82 Mississippi counties

Magnolia Health Mississippi Children's Health Insurance Program (CHIP)

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Mississippi Children's Health Insurance Program

- The Children's Health Insurance Program ("CHIP") is designed to provide health care insurance for children in families without health insurance or with inadequate health insurance.
- CHIP covers children from birth to age 19.
- CHIP is administered by the Mississippi Division of Medicaid ("hereinafter, "DOM").
- Eligibility is continuous for one year. There are no premiums or deductibles, although there may be a small co-payment for some services for higher-income families on CHIP.
- **The Magnolia Health Mississippi Children's Health Insurance Program (CHIP) will be effective on 01/01/2015.**

From Age	To Age	Above (%FPL)	Up to & Including (% FPL)
0	1	194	209
1	6	133	209
6	19	133	209

Ambetter from Magnolia Health

Ambetter from Magnolia Health delivers local, helpful and affordable healthcare coverage designed with your members in mind.

Local

- We live and work in Mississippi.
- We partner with local health care providers and community organizations to provide care for our members

Helpful

- We offer valued guidance and assistance to make health insurance accessible
- We remove barriers to make it simple to get well, stay well, and be well.

Affordable

- We offer affordable coverage and benefits.
- We provide well-rounded services and choices to help our members achieve their best health.

Verify Eligibility

It is highly recommended to verify member eligibility on the date services are rendered due to changes that occur throughout the month, using one of the following methods:

- **Log on to the Medicaid Envision website at: WWW.ms-medicaid.com/msenvision/ (MSCAN/CHIP ONLY)**
- **Log on to the secure provider portal at WWW.MagnoliaHealthPlan.com**
- **Call our automated member eligibility interactive voice response (IVR) system at 1-866-912-6285 (MSCAN/CHIP) 1-877-687-1187 (Ambetter)**
- **Call Magnolia Provider Services at 1-866-912-6285 (MSCAN/CHIP) or 1-877-687-1187 (Ambetter)**

(MEMBER ID CARDS ARE NOT A GUARANTEE OF ELIGIBILITY AND/OR PAYMENT)

Contracting/Credentialing Transition from Univita

- All providers contracted with Univita were contacted in August 2014 by the Magnolia Network Development & Contracting team to advise of the pending Univita contract termination and information to contract directly with Magnolia for the 12/01/14 transition date.

- Providers that were previously contracted with Univita and have not had contract communication from Magnolia, please contact Brad Baker – Senior Contract Negotiator (601-863-0789) or submit a contract request form (CRF) and a W-9 to 1-866-480-3227. Contract request forms can be found on the Magnolia website www.magnoliahealthplan.com

Contracting/Credentialing Transition from Univita

- Effective 12/01/14, all DME, HH, HI providers will contract directly with Magnolia Health
- Upon receipt of a contract request form (CRF), a contract negotiator will build a ancillary agreement and submit to the provider for review using the email address provided in the CRF.
- During the credentialing process, it is important to obtain an prior authorization for all services until network participation has been approved.

Benefits and Limitations – MSCAN

DME

- Durable Medical Equipment is covered in accordance to the Medicaid guidelines.
- Magnolia reimburses 100% of Medicaid benefits for PAR providers. Effective 09/01/14, NON PAR providers will be reimbursed 80% of Medicaid's fee schedule with a prior authorization.*
- Authorization is required for some DME. Providers should utilize the Pre-Auth tool to determine if the HCPCS code requires authorization.
- DME is covered based on medical necessity.

Orthotics and Prosthetics (O&P)

- O&P are covered for members under the age of 21.
- Items categorized as orthotics are sleeves or braces.
- Items categorized as prosthetics are items physically attached to the body (legs, hands, arms, etc.)
- Orthotics and Prosthetics will be authorized by HCPCS codes. Providers will need to utilize the Pre-Auth tool to determine if a Prior Authorization is required.

Additional information will be provided at a later time regarding this benefit

Benefits and Limitations – CHIP

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Mississippi Children's Health Insurance Program

DME

- Durable Medical Equipment is covered in accordance to the CHIP guidelines.
- Magnolia reimburses 100% of benefits for PAR providers.
- There are no out of network benefits provided for CHIP DME.*
- Authorization is required for some DME. Providers should utilize the Pre-Auth tool to determine if the HCPCS code requires authorization.
- DME is covered based on medical necessity.

Orthotics and Prosthetics (O&P)

- O&P are covered for all members.
- Prior authorization is required. Out of network benefits are reimbursed at 100%.*
- Items categorized as prosthetics are items physically attached to the body (legs, hands, arms, etc.)
- Orthotics and Prosthetics will be authorized by HCPCS codes. Providers will need to utilize the Pre-Auth tool to determine if a Prior Authorization is required.

Additional information will be provided at a later time regarding this benefit

Benefits and Limitations - Ambetter

DME

- Durable Medical Equipment is covered in accordance to the Medicare guidelines.
- Ambetter reimburses 100% of benefits for PAR providers.*
- Authorization is required for some DME. Providers should utilize the Pre-Auth tool to determine if the HCPCS code requires authorization.
- DME is covered based on medical necessity.

Orthotics and Prosthetics (O&P)

- O&P are covered for all members.
- Items categorized as orthotics are sleeves or braces.
- Items categorized as prosthetics are items physically attached to the body (legs, hands, arms, etc.)
- Orthotics and Prosthetics will be authorized by HCPCS codes. Providers will need to utilize the Pre-Auth tool to determine if a Prior Authorization is required

Additional information will be provided at a later time regarding this benefit

Please note: There are currently no out of network benefits provided.

Benefits and Limitations – MSCAN

Home Health Care

- Coverage includes traditional home care, home therapies, home medical equipment, and private duty nursing.
- Services do require prior authorization and are limited to 25 visits per year and Home-based OT/PT/ST is a non-covered benefit for members 21 years and older.

Home Infusion

- Coverage includes Enteral Nutrition, pumps, hydration, antibiotic therapy, and total parenteral nutrition.
- Services require prior authorization.

Hospice Care

- Requires prior authorization.
- Inpatient, Outpatient, hospital based, and home hospice is covered.
- The requesting provider must submit all documentation listed in the MS Division of Medicaid's Administrative Code Title 23: Medicaid Part 205 Hospice Services.
- NON PAR providers are reimbursed 100% of benefits.*

Additional information will be provided at a later time regarding this benefit

Benefits and Limitations - CHIP

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Mississippi Children's Health Insurance Program

Home Health Care

- Coverage includes traditional home care, home therapies, home medical equipment, and private duty nursing.
- Services do require prior authorization.
- OT/PT/ST are covered benefits and paid at 100% for PAR and NON PAR providers.
- Skilled Nursing services are limited to 60 days per benefit per, covered at 100% for PAR and NON PAR providers.
- Private duty nursing is limited to a Lifetime Max of $15,000 per member and requires prior authorization. Benefits are paid at 100% for PAR and NON PAR providers.

Home Infusion

- Covered at 100% for PAR providers. Out of network benefits are not provided for this service.*
- Services require prior authorization.

Hospice Care

- Requires prior authorization.
- Inpatient, Outpatient, hospital based, and home hospice is covered.
- Limited to a Lifetime Max of $15,000 per member for CHIP.*
- NON PAR providers are reimbursed 100% of benefits.*

Additional information will be provided at a later time regarding this benefit

Benefits and Limitations – Ambetter

Home Health Care

- Home health care, including home-based therapy , requires authorization.
- Coverage includes traditional home care, home therapies, home medical equipment, and private duty nursing.
- Skilled nursing services are covered if in network.

Home Infusion

- Coverage includes Enteral Nutrition, pumps, hydration, antibiotic therapy, and total parenteral nutrition.
- Services require prior authorization.

Hospice Care

- Requires prior authorization.
- Inpatient, Outpatient, hospital based, and home hospice is covered.
- Only covered for six months.

Please note: There are currently no out of network benefits provided.

Fee Schedule and Policy

You may access the fee schedule at the DME page of the MS Medicaid website:

http://medicaid.ms.gov/DMEandMedSupply.aspx

Detailed policy manuals are available in Section 209 of the Administrative Code Policy Manuals and can be retrieved at the following link:

http://www.medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-209.pdf

Cultural Awareness and Sensitivity

Providers must ensure that:

- Members understand that they have access to medical interpreters, signers, and TDD/TTY services to facilitate communication without cost to them.

- Medical care is provided with consideration of the member's race/ethnicity and language and its impact/influence of the member's health or illness.

Waste, Abuse, and Fraud (WAF) System

Magnolia takes the detection, investigation, and prosecution of fraud and abuse very seriously. Our WAF program complies with MS and Federal laws, in conjunction with Centene, we successfully operate a WAF unit. Centene's Special Investigation Unit (SIU) performs back end audits which may result in taking appropriate action against those who commit waste, abuse, and/or fraud either individually or as a practice. These actions may include but are not limited to:

- Remedial education and/or training around eliminating the egregious action
- More stringent utilization review
- Recoupment of previously paid monies
- Termination of provider agreement or other contractual arrangement
- Civil and/or criminal prosecution
- Any other remedies available

If you suspect or witness a provider inappropriately billing or a member receiving inappropriate services, please call our anonymous and confidential hotline at 1-866-685-8664

Some of the most common WAF submissions seen are:

- Unbundling of codes
- Up-coding
- Add-on codes without primary HCPC
- Use of exclusion codes
- Excessive use of units
- Diagnosis and/or procedure code not consistent with the member's age and/or gender
- Misuse of benefits
- Claims for services not rendered

Prior Authorization vs. Referral

Prior Authorization

Prior Authorization is a request to the Magnolia UM (Utilization Management) department for approval of services on the prior authorization list before the service is rendered

Referrals

- PCP coordinates healthcare services and are encouraged to refer a member when medically necessary care is needed that is beyond the scope of the PCP
- Paper referrals are not required
- PCP must obtain prior authorization from Magnolia for referral to certain specialty providers as noted on the prior authorization list
- All out-of-network services require prior authorization as further described herein. Please refer to in network specialists (NO out-of-network benefits for Ambetter)

Pre-Auth Tool

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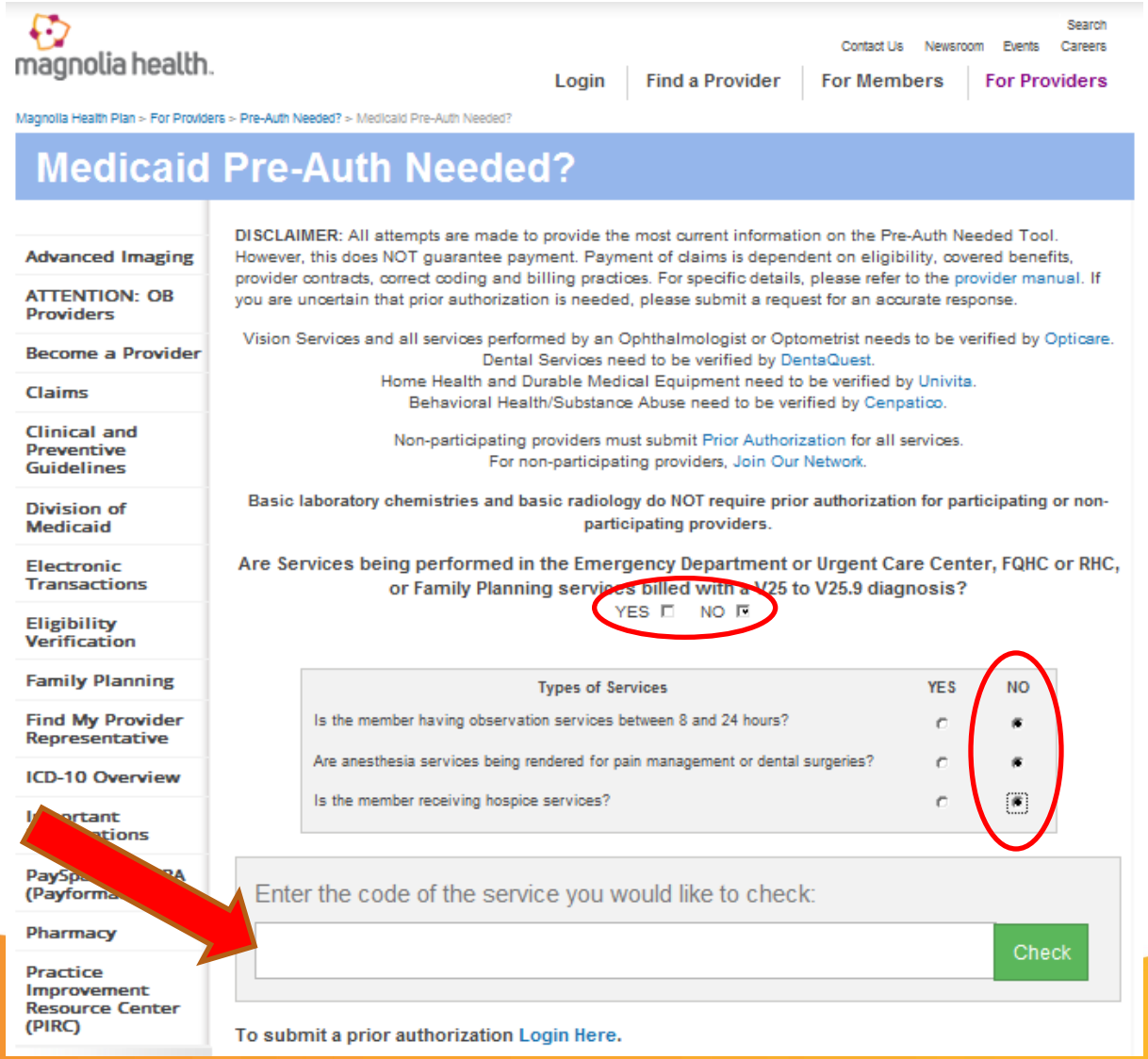
Magnolia offers the "Pre-Auth Needed" Tool for providers to verify if services require an authorization for convenience.

The tool is available for all products MSCAN, CHIP, Ambetter **(CHIP will be effective 01/01/15)**



Prior Authorization Process

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ALL OUT OF NETWORK SERVICES REQUIRE AN AUTHORIZATION

- Services that require authorizations can be found on Magnolia's website. www.magnoliahealthplan.com
- It is highly recommended to initiate the Authorization process at least **5** calendar days in advance for non-emergent services
- The PCP should contact the UM department via telephone, fax, secure email, or through our website with the appropriate clinical information to request an authorization
- Urgent requests can be requested from the Medical Management department as needed

(Emergency room and urgent care services never require prior authorization)

Prior Authorization Phone Requests:

MSCAN/CHIP – 1-866-912-6285

Ambetter – 1-877-687-1187

Prior Authorizations

A prior authorization form must be submitted prior to services being rendered for services that require authorization. Providers should ensure to complete the applicable form for Inpatient and Outpatient services.

It is highly recommended that providers utilize Magnolia's "Smart Sheet" to assist with Prior Authorization requests.

http://www.magnoliahealthplan.com/files/2010/11/PA-Smart-Sheet-How-To-PDF.pdf

Prior authorization lists are located at:

http://ambetter.magnoliahealthplan.com/files/2013/07/Quick-Reference-Guide.pdf

http://www.magnoliahealthplan.com/files/2010/11/Prior-Authorization-List-PDF1.pdf

Forms can be located on our websites at the following addresses:

http://ambetter.magnoliahealthplan.com/for-providers/provider-resources/

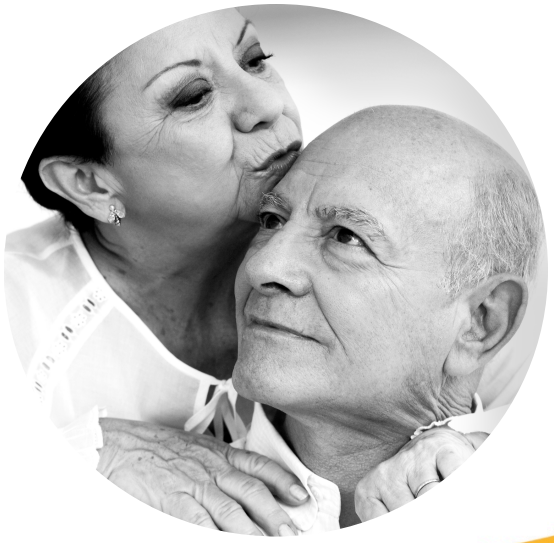
http://www.magnoliahealthplan.com/for-providers/provider-resources/

Requests can be faxed to:
1-877-650-6943 (Magnolia)
1-855-684-6747 (CHIP)
1-855-300-2618 (Ambetter)

Requests can be emailed securely to:
MagnoliaAuths@Centene.com

Care Management

- Magnolia's Care Management Program uses a multidisciplinary team approach to provide individualized process for assessment, goal planning and coordination of services.
- The Care Management Program is available to **all** members, emphasizing prevention and continuity of care.
- Magnolia's Care Management team provides assistance with complex medical conditions, health coaching for chronic conditions, transportation assistance to appointments, interpreter services, location of community resources, and encouragement of self-management through disease education.
- The Care Management team will incorporate the provider's plan for the member into our Care Plan, so we can focus on the same problems and same care interventions.



Pharmacy

USScript

- Pharmacy Benefit Manager
- Covers prescription drugs and certain over-the-counter (OTC)
- Some medications require a PA or have limits on age, dosage, and/or max quantities
- Preferred Drug List (PDL) is available at www.magnoliahealthplan.com in the **Practice Improvement Resource Center**

Contact USScript

Prior Authorization Fax 1-866-399-0929

Prior Authorization Phone 1-866-399-0928

Clinical Hours Monday - Friday 10:00 a.m.-8:00 p.m. (EST)

Help Desk Line 1-800-460-8988

Mailing Address US Script, 2425 W Shaw Ave, Fresno, CA 93711

Clinical Protocols

Magnolia affirms that utilization management decision making is based only on appropriateness of care and service and the existence of coverage. Magnolia does not specifically reward practitioners or other individuals for issuing denials of service or care. Consistent with 42 CFR 438.6(h) and 422.208, delegated providers must ensure that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.

Magnolia has adopted utilization review criteria developed by McKesson InterQual® products to determine medical necessity for healthcare services. InterQual appropriateness criteria are developed by specialists representing a national panel from community-based and academic practice. InterQual criteria cover medical and surgical admissions, outpatient procedures, referrals to specialists, and ancillary services. Criteria are established and periodically evaluated and updated with appropriate involvement from providers. InterQual is utilized as a screening guide and is not intended to be a substitute for practitioner judgment. Magnolia's Medical Director reviews all potential medical necessity denials and will make a decision in accordance with currently accepted medical or healthcare practices, taking into account special circumstances of each case that may require deviation from the norm in the screening criteria.

Please visit the Practice Improvement Resource Center (PIRC) at www.magnoliahealthplan.com for Clinical Practice Guideline and Preventative Guidelines

Claims Filing

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ALL Claims must be filed within 180 days from the Date of Service (DOS)

All requests for correction, reconsideration or adjustment must be received within 90(MSCAN/CHIP) or 180(Ambetter) days from the date of notification or denial

Providers should include a copy of the Explanation of Payment (EOP) when other insurance is involved or provide information when billing electronically

Option to file electronically through clearinghouse

Option to file directly through Magnolia website

Claims must be completed in accordance with Division of Medicaid billing guidelines

All member and provider information must be complete and accurate

Option to file on paper claim – 1ST time paper claims, mailed to:

Magnolia Health Plan
Attn: CLAIMS DEPARTMENT
P.O. Box 3090(MSCAN)
P.O. Box 5040(CHIP)
P.O. Box 5010(Ambetter)
Farmington, MO 63640-3825

Paper claims are to be filed on approved CMS 1500 (NO HANDWRITTEN OR BLACK AND WHITE COPIES)

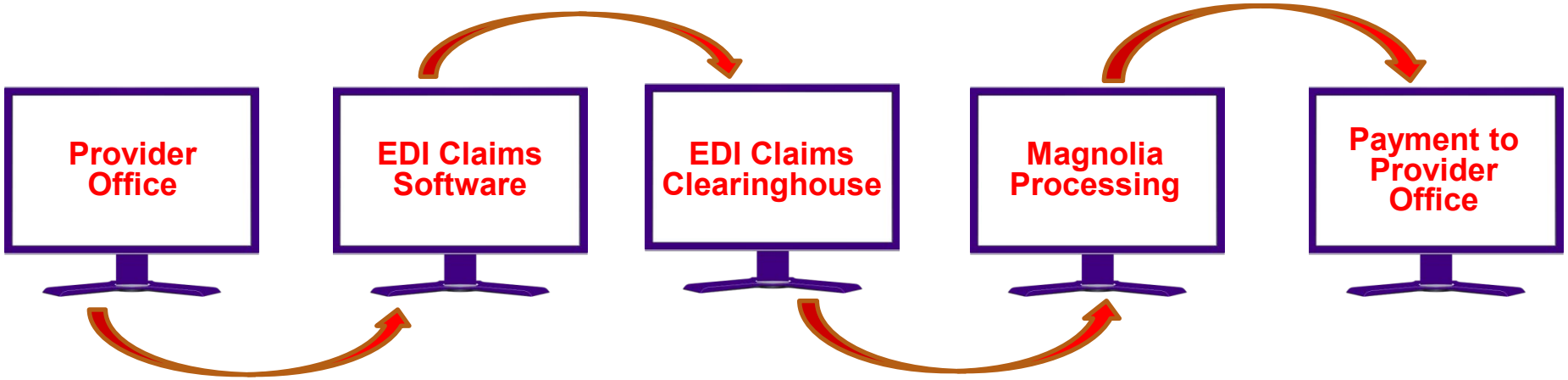
To assist our mail center in improving the speed and accuracy to complete scanning please take the following steps when filing paper claims:

- Remove all staples from pages
- Do not fold the forms
- Make sure claim information is dark and legible
- Please use a 12pt font or larger
- Please use the CMS 1500 printed in red (*Approved OMB-0938-1197 Form CMS-1500 (02-12)*
- Red and White approved claim forms are required when filing paper claims as our Optical Character Recognition ORC scanner system will put the information directly into our system. This speeds up the process and eliminates potential sources for errors and helps get your claims processed faster

FILE ONLINE AT WWW.MAGNOLIAHEALTHPLAN.COM!

Electronic Clearinghouse

- If a provider uses EDI software but is not setup with a clearinghouse, they must bill MHP via paper claims or through our website until the provider has established a relationship with a clearinghouse listed on our website



- Centene EDI Help desk: 1-800-225-2573, ext. 25525 or WWW.EDIBA@CENTENE.COM
- Acceptance of COB
- 24/7 Submission
- 24/7 Status

For a complete listing of approved EDI clearinghouse partners, please refer to MagnoliaHealthPlan.com

Corrected Claim, Reconsideration, Claim Dispute

All Requests for corrected claims, reconsiderations or claim disputes must be received within **90 days(MSCAN/CHIP) or 180 days(Ambetter)** of the original Plan notification (ie. EOP). Original Plan determination will be upheld for requests received outside of the **90 or 180 day** timeframe, unless justification is provided to the Plan to consider

Corrected Claims

- Submit via Secure Web Portal
- Submit via an EDI Clearinghouse

- Submit via paper claim:
  - **Magnolia Health**
  - **PO BOX 3090(MSCAN)**
  - **PO BOX 5040(CHIP)**
  - **PO BOX 5010(Ambetter)**
  - **Farmington, MO 63640**
  - **(Include original EOP)**

Reconsideration

- Written communication (i.e. letter) outlining disagreement of claim determination
- Indicate "Reconsideration of (original claim number)"

- Submit reconsider to:
  - **Magnolia Health**
  - **Attn: Reconsideration**
  - **PO BOX 3090(MSCAN)**
  - **PO BOX 5040(CHIP)**
  - **PO BOX 5010(Ambetter)**
  - **Farmington, MO 63640**

Claim Dispute

- ONLY used when disputing determination of Reconsideration request
- Must complete Claim Dispute form located on **MagnoliaHealthPlan.com**
- Include original request for reconsideration letter and the Plan response

- Send Claim Dispute form and supporting documentation to:
  - **Magnolia Health**
  - **Attn: Claim Dispute**
  - **PO BOX 3090(MSCAN)**
  - **PO BOX 5040(CHIP)**
  - **PO BOX 5010(Ambetter)**
  - **Farmington, MO 63640**

Must be submitted within 90 or 180 days of adjudication

Complaints/Grievances

A Complaint/Grievance is a verbal or written expression by a provider which indicates dissatisfaction or dispute with Magnolia Health's policies, procedures, or any aspect of Magnolia Health's functions. Magnolia logs and tracks all Complaints/Grievances. A provider has **thirty (30) calendar days** from the date of the incident, such as the date of the EOP, to file a Complaint/Grievance. Magnolia shall provide a written determination to the provider within **thirty (30) calendar days** upon receipt of complete documentation.

The Reconsideration and/or Claim Dispute process must be followed first for Complaint/Grievance related to a claim determination.

Full details of the claim reconsideration, claim dispute, complaints/grievances and appeals processes can be found in our Provider Manual at: MagnoliaHealthPlan.com

Authorization Complaints

Authorization and coverage complaints must follow the Appeal process. **Claim decisions are NOT Appealable and must follow the Reconsideration and/or Claim Dispute process.**

An Appeal allows providers to challenge the determination of a Prior Authorization request. A Provider has **thirty (30) calendar days** from Magnolia Health's notice of action to file an Appeal. Magnolia shall resolve and provide a written notice of the Appeal request within **thirty (30) calendar days** upon receipt of all Appeal documentation or as required dependent on members health condition. Magnolia Health may extend resolution timeframe to **fourteen (14) calendar days** upon member request or need for additional information.

Expedited Appeal requests are resolved as expeditiously as the members health condition requires, not to exceed **seventy-two (72) hours** form the initial Appeal receipt. Magnolia Health may extend resolution timeframe to **fourteen (14) calendar days** upon member request or need for additional information that is in the members best interest.

Full details of the claim reconsideration, claim dispute, complaints/grievances and appeals processes can be found in our Provider Manual at: MagnoliaHealthPlan.com

Taxonomy Code / CLIA

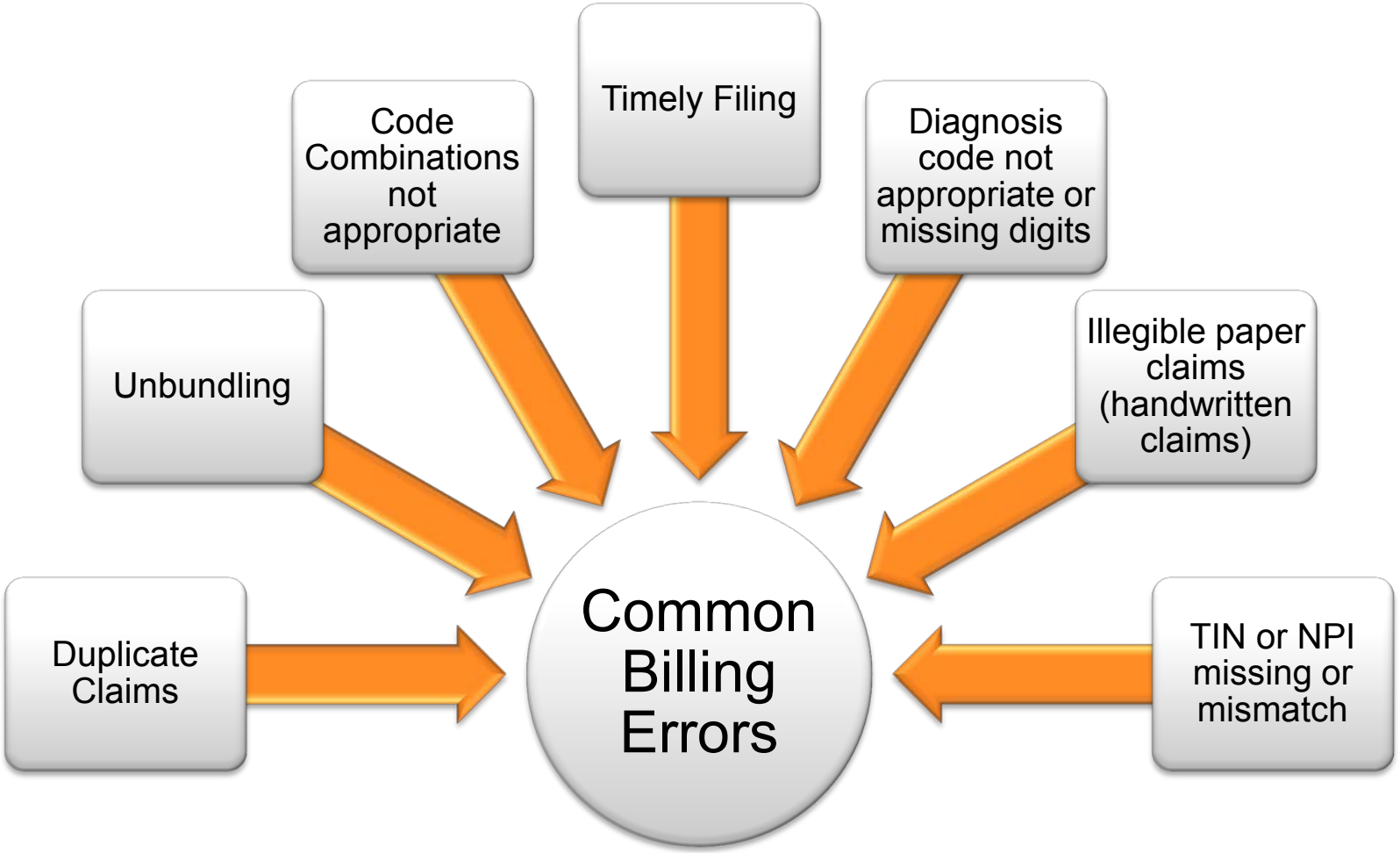
Rendering Taxonomy Code:

- Claims must be submitted with the rendering provider's taxonomy code in the **shaded** portion of Box 24J and Taxonomy qualifier "ZZ" in the **shaded** portion of Box 24I if the rendering NPI and billing NPI are different
- If the rendering NPI and billing NPI are the same, the applicable taxonomy utilizing the "ZZ" Qualifier is filed in Box 33b
- **The claim will reject if the taxonomy code is not present**
- CMS 1500 form – Box 33b, group Taxonomy utilizing the "ZZ" qualifier in Box 33b if the rendering NPI and billing NPI differ
- CMS 1450 form – Box 81 CC, Taxonomy code with B3 Qualifier
- This is necessary in order to accurately adjudicate the claim
- The following website can be utilized to verify a taxonomy code: www.findacode.com/tools/taxonomy-codes.html

CLIA Number:

- If the claim contains CLIA certified or CLIA waived services, the CLIA number must be entered in Box 23 of a paper claim form or in the appropriate loop for EDI claims
- Claims will be rejected if the CLIA number is not on the claim

Common Billing Errors



For a complete list of common billing errors refer to the claims filing manual and provider manual

Reimbursement

Durable Medical Equipment (DME) Payment/Reimbursement Policies*

The payment for purchase of new durable medical equipment is made from a statewide uniform fee schedule which is updated by July 1 of each year and is effective for services provided on or after that date based on one of the following instances:

- The lesser of the provider's usual and customary charge or:
- 80% of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DEMPOS) fee schedule in effect by January 1.
- If no DEMPOS fee is available and a fee cannot be calculated the item will be manually priced at the Manufacturer's Suggested Retail Price (MSRP) minus 20% to provide the 80% price range that is offered by Medicare. (Items that do not have a fee or MSRP may be priced at the provider's cost plus 20 %.)

Additional information will be provided at a later time regarding CHIP and Ambetter reimbursement.

Reimbursement

- The payment for the rental of DME is made from a statewide uniform fee schedule which is based on 10% of the purchase allowance for new DME not to exceed 10 months. After the rental benefits are paid for 10 month, the equipment becomes property of the beneficiary/member unless, otherwise authorized by the Division of Medicaid through specific coverage criteria.
- The payment for purchase of used DME also follows the uniform fee schedule and cannot exceed more than 50% of the new DME purchase allowance.
- The payment of repair of DME equipment also cannot exceed 50% of the new DME purchase allowance.
- The payment for other individual consideration items must receive prior authorization from the Utilization Management Department.

Additional information will be provided at a later time regarding CHIP and Ambetter reimbursement.

Magnolia Health Website

Submit:

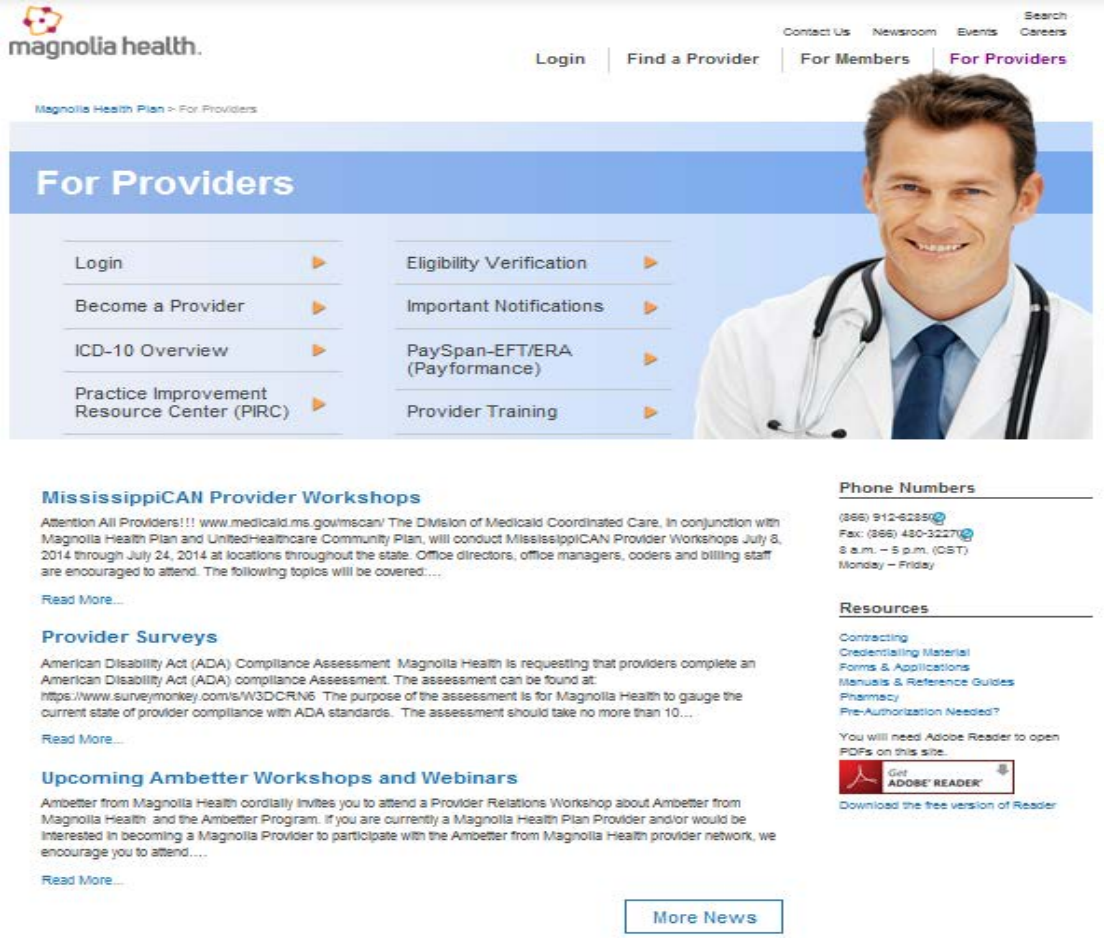
- Claims
- Provider Complaints
- Demographic Updates

Verify:

- Eligibility
- Claim Status

View:

- Provider Directory
- Important Notifications
- Provider Training Schedule
- Practice Improvement Resource Center (PIRC)
- Claim Editing Software
- Provider Newsletter
- Member Roster for PCPs
- Member Care Gaps



www.MagnoliaHealthPlan.com

Ambetter from Magnolia Website

Submit:

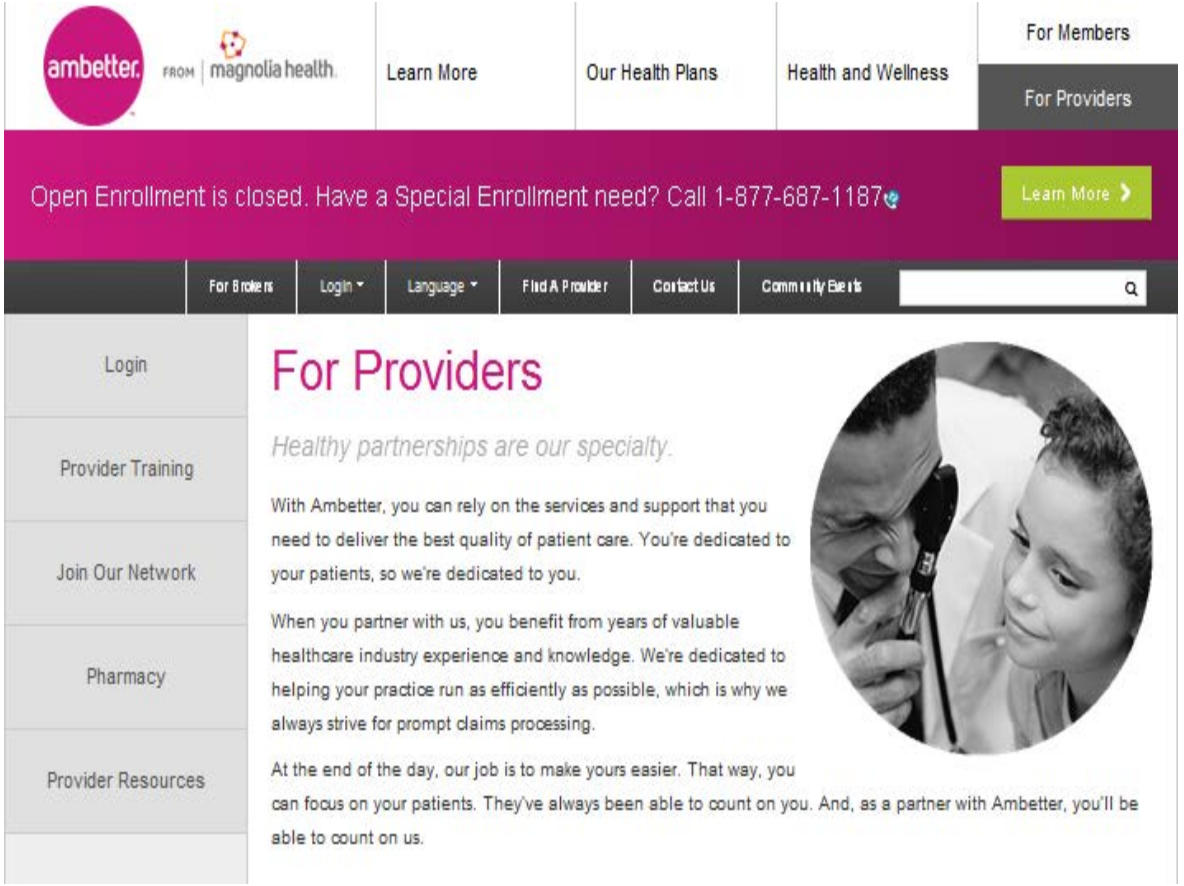
- Claims
- Demographic Updates

Verify:

- Eligibility
- Claim Status

View:

- Provider Manual
- Billing Manual
- Quick Reference Guides
- Forms
- Prior Authorization Pre-Screen Tool
- Pharmacy Preferred Drug Listing
- Affordable Care Act Overview
- Provider Training Schedule
- And more Provider Resources….



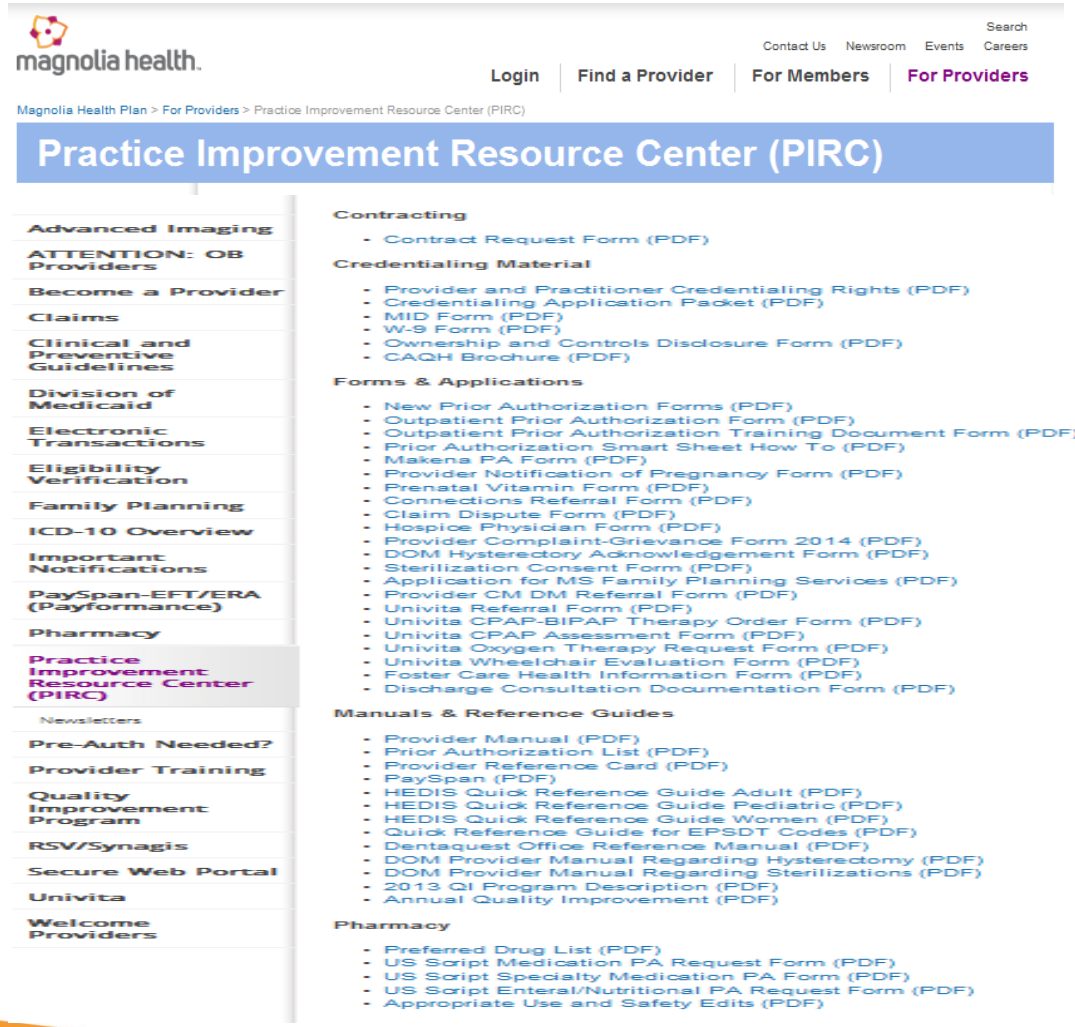
www.Ambetter.MagnoliaHealthPlan.com

Practice Improvement Resource Center (PIRC)

The Practice Improvement Resource Center (PIRC) offers information to assist providers be more efficient and make resources available 24 hours a day:

Forms and Guides for the following:

- Contracting/Credentialing
- Prior Authorizations
- Claims
- Provider Manual
- Magnolia Vendors
- HEDIS Reference Guides
- Pharmacy PDL's and Guides
- Provider Training
- Clinical Practice Guidelines
- Updates….. and more!!

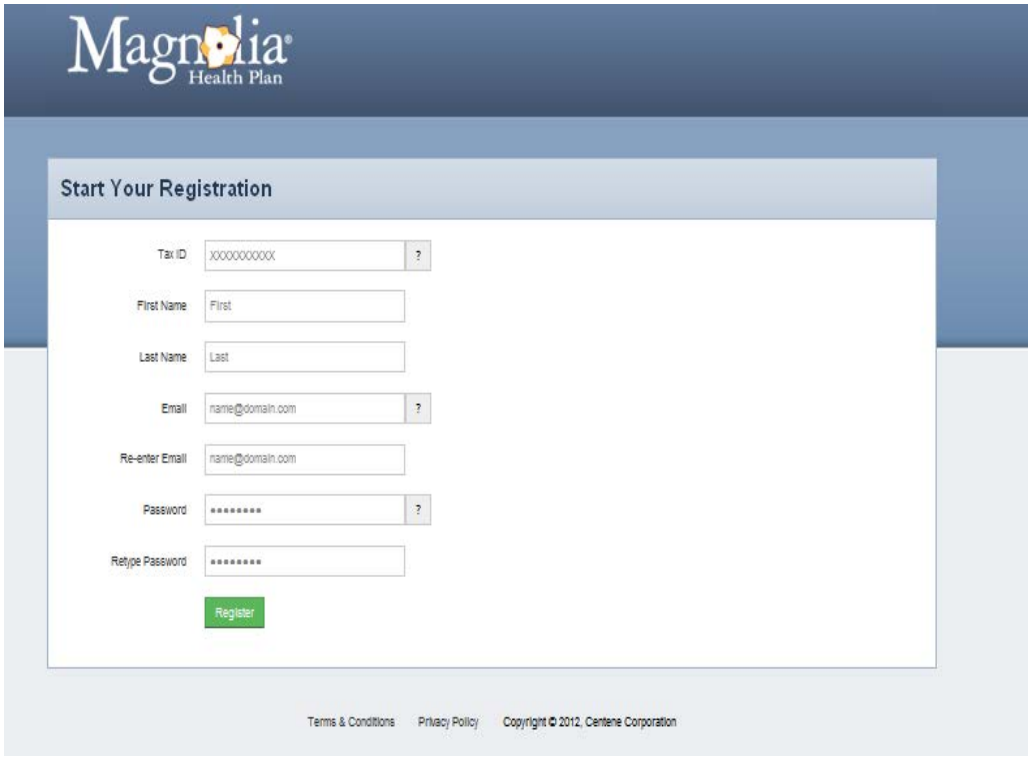


Magnolia Secure Web Portal

REGISTER FOR THE MAGNOLIA SECURE WEB PORTAL

BENEFITS INCLUDE:

- Claim submission/corrections and status
- Prior Authorizations submission and status
- Patient Panel listing
- Care gap identification
- Member eligibility verification
- Updates….. and more!!

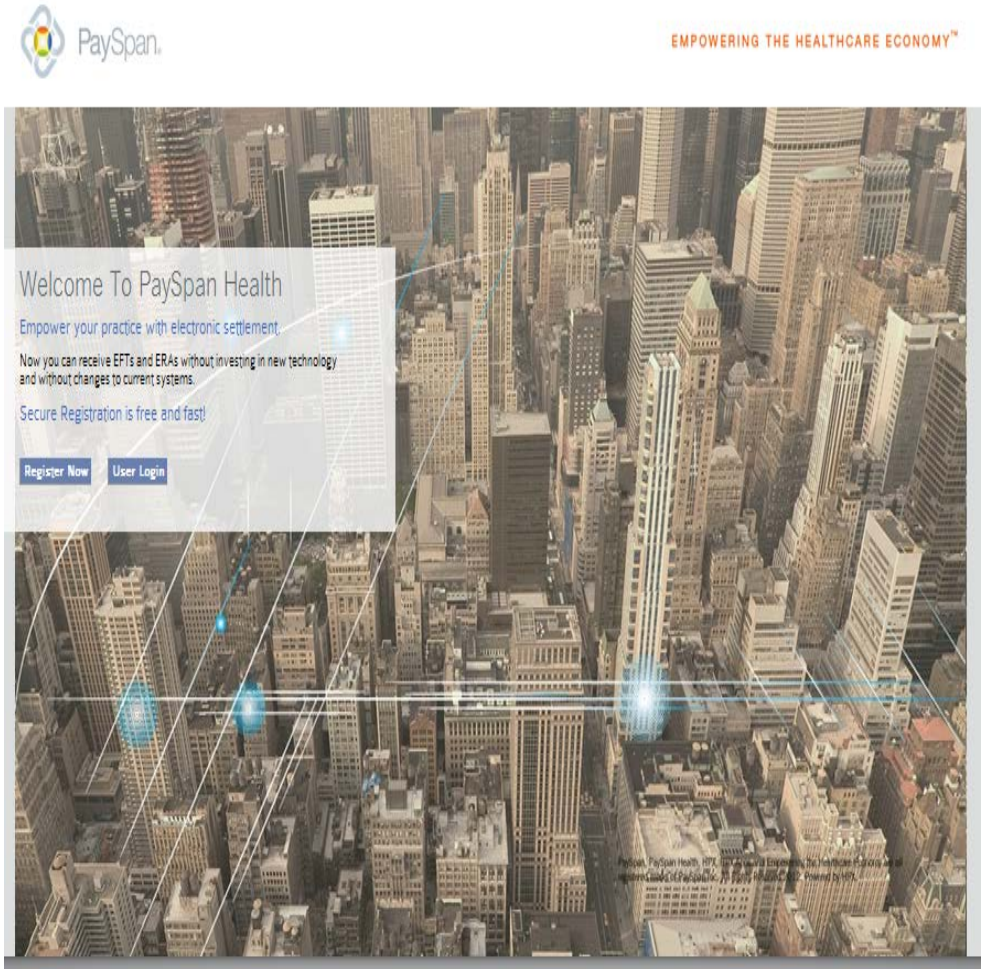


MRI * CT SCAN * PET SCAN Authorization

- An authorization is required for MRI-CT SCAN-PET SCANS
- National Imaging Associates (NIA) has been selected by MHP to administer the program
- **The servicing provider (PCP or Specialist) will be responsible for obtaining authorization for the procedures**
- Servicing providers may request authorization and check status of an authorization by:
  - Accessing www.radmd.com
  - Utilizing the toll free number 1-800-642-7554
- Inpatient and ER procedures will not require authorization
- All claims should be submitted to MHP through the normal processes, www.magnoliahealthplan.com, electronic submission or paper claim submission
- Providers can contact Charmaine Gaymon, Provider Relations Manager at 410-953-2615 or via email at CSGaymon@magellanhealth.com

PaySpan Health

- Magnolia has partnered with PaySpan Health to offer expanded claim payment services
- Electronic Claim Payments (EFT)
- Online remittance advices (ERA's/EOPs)
- HIPAA 835 electronic remittance files for download directly to HIPAA-compliant Practice Management or Patient Accounting System
- Register at: **www.PaySpanHealth.com**



For further information contact 1-877-331-7154, or email Providerssupport@PAYSPANHEALTH.COM

Contact

Univita- (Until 11/30/14)

Phone: 1-888-914-2201

Fax: 1-888-914-2202

Magnolia Health/CHIP

Phone: 1-866-912-6285

http://www.magnoliahealthplan.com/

Ambetter

Phone: 1-877-687-1187

Fax: 1-855-300-2618

http://ambetter.magnoliahealthplan.com/files/2013/07/Quick-Reference-Guide.pdf

Provider Relations

Please call **1-866-912-6285** to get in contact with the Provider Relations Department

Frequently Asked Questions

- Who will service the equipment and supplies for Magnolia Health member needs after 12/1/14?
  - Please call Magnolia Health at 866-912-6285 or Ambetter at 877-687-1187. If you need to submit a request for authorization, you may also fax your MSCAN/CHIP requests to 877-650-6943 or Ambetter requests to 855-300-2618.

- I provided services prior to 12/1 but did not bill for services. Where do I send my claim?
  - Submit claims and all documentation for services performed prior to 12/1/14 to Univita within 180 days of the original date of service. We highly recommend that you send claims within 90 days of the original date of service.

- I am a provider with multiple Magnolia members on service. How does their authorization information get to Magnolia?
  - Univita has provided a complete listing of all open Univita authorizations to the health plan. For items that require authorization from the health plan for service after November 30, please follow the process established by Magnolia.

- What items require an authorization from the health plan?
  - Please contact Magnolia at 866-912-6285 or Ambetter at 877-687-1187 or go online to http://www.magnoliahealthplan.com to obtain this information. Prior Authorization list is located under Practice Improvement Resource Center.

magnolia health™

Thank you!